Department of Medical Assistance Services
Division of Long Term Care

TECHNOLOGY ASSISTED WAIVER SUPERVISORY MONTHLY SUMMARY

Agency: _____ Date of Supervisory Visit: _____

Primary Caregiver: _____ Previous Month of Service Reported: _____

Individual's Name: _____ Medicaid #: _____

Orders Renewal Date: _____ Primary Diagnosis: _____

Individual attends school with a TW nurse? Yes No

Health, safety and welfare needs met? Yes No
(If no, document problem below and **notify DMAS immediately**)

Nursing hours authorized/day: _____ Respite hours provided: _____ Total Respite hours used to date: _____

CLINICAL STATUS THIS MONTH (illnesses, MD order changes, scheduled procedures, etc. Do not document "no change") _____
_____
_____
_____

PROBLEMS / CHANGES NOTED WITH DME (too much, too little, improper usage, agency): _____
_____

TECHNOLOGY / NURSING NEEDS: (Circle Answer) Ventilator CPAP BIPAP – continuous intermittent

Oxygen: continuous intermittent PRN

Enteral feedings: continuous q2hrs. q3hrs. Q4hrs+

IV/Hyperal: continuous 8-16hrs. 4-7hrs. <4hrs.

Oral Supplements: _____
(type, frequency, amount)

Trach Care: QD BID TID Trach Change: weekly <weekly Suctioning: qhr. Q1-4hrs. q4hrs+

Other dressings: _____ q8hrs or less >q8hrs
(Specify type and location)

Medication changes:_____
_____

Peritoneal dialysis (frequency and length) _____

Catheterization: q4hrs q8hrs q12hrs QD PRN Special TX: _____ QID TID BID QD

Specialized monitor I/O (reason): _____frequency _____

Other skilled nursing (specify): _____

Has any technology been discontinued for this individual? Yes No **(If yes, notify the DMAS Health Care Coordinator immediately)**

HOSPITALIZATIONS / REASONS: (Call DMAS to notify) _____

THERAPIES (name of provider, frequency, location, progress):_ _____

CURRENT MD PLAN OF TREATMENT IN THE HOME CHART? Yes No **COPY SENT TO DMAS**? Yes No

CAREGIVER /INDIVIDUAL'S RESPONSE TO NURSING SERVICES: _____

DATE OF CONTACT WITH FAMILY / CAREGIVER: _____During Home Visit ❒ and / or Via Phone ❒

NURSES STAFFING CASE THIS MONTH: (If no nursing for 30 days or more notify the DMAS Health Care Coordinator)
_____

PROBLEMS IDENTIFIED _____

INDIVIDUAL'S / FAMILY'S SIGNATURE (If available)_____

_____ _____ _____
RN SUPERVISOR'S SIGNATURE AGENCY PHONE # DATE